Simmons has used with great success, jaborandi and pilocarpine. He reinforces with advantage this last medication with vapor baths given with the patient in his bed. He treats a failing pulse with caffeine.

Edema of the glottis necessitates tracheotomy.

In the paralytic form of beri-beri, the girdle pains may be relieved with aconite, belladonna, bromide of potassium or ergot to allay the spinal hyperemia. Friction and electricity may be used for the paralyses. One should use great care in the employment of strychnine in the treatment of beri-beri. The general tone should be raised with cinchona, kola, iron and arsenical preparations (Fowler's solution and Boudin's fluid). The latter are, moreover, of advantage in combating chronic malaria, often associated with beri-beri.

Counter irritation along the spinal column (actual cautery, blistering agents and tincture of iodine) have been employed by some physicians. The blisters are inconvenient in predisposing to bed sores. Iodine of potash is indicated in the chronic forms of the disease.

(d) Lumbar Puncture. We think that lumbar puncture or lumbo-sacral puncture would be of great service in the treatment of beri-beri. There are, in fact, distinct indications for active surgical intervention, the constant presence of a large quantity of serum in the spinal canal, constrictive pains of the thorax, dyspnea with angina, filiform pulse, etc. We advise the use of this operation, which is entirely harmless and is coming into general use.

SAN FRANCISCO COUNTY.

Paper by Dr. W. C. Voorsanger, "Aneurysm of the Left Ventricle."

Dr. D'Arcy Power, discussing: Undoubtedly cases of aneurysm of the heart are extremely rare, and I doubt whether it is possible to make a diagnosis except by most careful auscultation. Even with the radiograph I think that we shall not be able to do much. The same thing is true of aneurysms of the first part of the aorta. I have examined cases which have turned out to be aneurysm of the first part of the aorta in which there were neither physical signs nor symptoms. So far as aneurysm of the heart itself is concerned I think we shall always be in the same position, i. e., that the majority of cases will be diagnosed post mortem.

Dr. Cooper, discussing: Of late considerable advance has been made in chest radiography. We can now at a distance of six feet obtain a chest radiogram during suspended respiration, even in dyspnaic people. Such a picture is practically an othho-radiogram. The value of such work in the diagnosis of aneurysm of the heart depends upon whether the aneurysm makes a projection of the heart surface so as to throw an abnormal shadow outline either in the sagittal or coronal plane. If so, then radiography will probably be of much assistance.

Paper by C. G. Levision, "Intestinal Obstruction."

Dr. Barbat, discussing: The only thing that I can add in regard to these cases of obstruction which are due to hernia is that resection of the bowel should certainly be practiced if the patient has not been too thoroughly poisoned by waiting. I prefer making the resection with an end to end anastomosis, the Murphy button serving good purpose. The cases which the doctor did not speak of in his paper are the cases of adynamic ileus. Operation is practically of no avail. The disease has started outside of the intestine or it has arrived at the outside some time before being seen by a medical man or a surgeon, and these cases are particularly hopeless. In cases of obstruction if seen early enough, I advise radical operation and not enterostomy. If the patient is poisoned and is in a serious septic condition, then enterostomy followed by radical operation is the correct surgery.

Dr. Schmoll, discussing: One cannot help being impressed by this appeal to the physician to refer cases for operation early. So far as the physician is concerned, only cases of ileus which occur in the slowly obstructing process can be considered as cases of strangulating ileus are referred to the surgeon right in the beginning. If we understand the paper correctly, Dr. Levison appeals to the physician to refer cases of slowly occurring obstruction at the stage when radical operation is possible. Under what condition can the physician diagnose these cases? The first symptom in such cases is constipation and I think it is a general mistake for the practitioner not to pay sufficient attention to the symptom complex of constipation. I confess that many errors of diagnosis I have committed have been due to the fact that I did not examine the patients with constipation sufficiently. Every case of constipation has to be gone into very thoroughly and I think every case in which constipation occurs after the age of 40 without any previous history of constipation is highly suspicious of beginning obstruction of the intestine. Very frequently I have seen in beginning carcinoma, periods of constipation alternated with periods of diarrhea, and in such cases one finds traces of blood or some pus in the diarrhetic stool; another point to which not sufficient attention is placed is the visible peristalsis. This occurs in almost every case if the patient is observed sufficiently. I remember a case which I have seen lately in which obstruction of the pylorus existed ten years. The diagnosis has not been made. I had to observe the case about a week until I saw visible peristalsis. Examination has to be extended for fifteen or twenty minutes and very frequently the visible peristalsis can be caused by tapping the suspicious place with a wet towel.

Dr. D'Arcy Power, discussing: The cases which puzzle the physician are those in which these typical symptoms are not met. Take, for example, the question of constipation occurring in patients after 40 years of age. Most females after this age are constipated, and yet it is the very age at which you get intestinal carcinoma. The old idea is wrong that carcinoma is associated with pain, cachexia and obstruction; in fact, so far as intestinal carcinoma is concerned, the great majority of cases are painless and cachexia is rarely present. I have in mind a case in which Dr. Terry and I were consultants. The patient had never been constipated or in any way sick or abnormal, but one day the normal defecation failed. There was no visible peristalsis, pain or distension, nor any marked toxemia or discomfort on the part of the patient. Purgatives and enemata gave no relief. On the fifth day when the abdomen was opened, we found complete obstruction of the transverse colon; it was absolutely blocked by a ring of carcinomatous tissue, yet there was nothing in the previous history or final development of the case which could have called attention to this condition. Thus there must always be a large number of these cases that never can be diagnosed until they are on the table, and then it is often too late.

Dr. Philip King Brown, discussing: One interesting thing in connection with this question of bowel obstruction is the remarkable contrasts that one sees in the cause of the obstruction. On the one hand, lymphosarcoma may almost fill the much-distended abdominal cavity, leaving scarcely a foot of the bowel uninvolved, and there will be no symptom of obstruction, while on the other hand a few strands of adhesions between the gall bladder and pylorus or duodenum, or between the bowel and the scar of a

hysterectomy, or in connection with a hernia, or following a diverticulitis, and one may find the most violent pain, and even a fatal obstruction. To the medical man, adhesions are vastly more commonly considered as a cause of complete or partial obstruction than anything else. Another point of extreme interest in this connection is the fact that these adhesions may exist many, many years without causing a single symptom, only to thrust themselves conspicuously into the foreground very suddenly, bringing about within a few hours conditions which threaten death. I regret to say that nearly every case that I have seen of acute obstruction due to adhesions has been operated on too late to give the patient the maximum chance of recovery. This has not always been any one's fault, for it is difficult sometimes to persuade even physicians of the extreme importance of early operation.

Dr. C. M. Cooper, discussing: In considering the diagnosis of intestinal obstruction we must bear in mind:

1. That diseases of the lung and pleura can by the irritation of the intercostal nerves, or by stimulation of the dorsal spinal segments, produce a condition strongly imitating an acute obstruction. The key to the situation lies in the disturbed respiratory pulse rhythm.

2. That in uremia the poisons produced may apparently paralyze the gut muscles, and hence the urine must always be investigated.

3. That the crises of locomotor ataxia may affect the intestine as well or independently of the stomach and so cause anomalous pictures.

4. That in lead poisoning such marked constipation may be present as to lead one astray if one does not systematically examine the gums for the blue line.

5. That auscultation of the abdomen is of considerable service, and we may conclude that if no murmur be heard for five minutes, obstruction is probably present.

I am glad Dr. Levison has called attention to the importance of thorough investigation of middle-aged people who come to us complaining of recently developed constipation and gas pains. In that investigation the sigmoidoscope is very serviceable, and if one will give the patient some charcoal about twenty-four hours previously to the sigmoidoscopic examination, oftentimes useful information relative to the passage of the food through the intestine to the rectum can be simultaneously obtained, and one can definitely determine that there is no obstruction higher up. The recent work of Hummel on the value of the X-Ray in the early diagnosis of these cases is so convincing as to speak for itself.

Dr. F. B. Carpenter, discussing: In the matter of operation, whether it should be radical, or whether one should content himself with enterostomy, depends greatly upon personal equation. It is evident to all of us that one man can do an operation very quickly, whereas another man fully realizes that he can not do the same operation in the same length of time; that man should be content with a temporary operation and subsequently do the secondary, whereas another man might do the complete operation at once. Another point of importance is that of stimulation for patients. Those of us who have watched the effects of interne work in the hospitals, and have left patients in charge of internes, have found invariably that the interne loaded the patients up with about everything he has learned in his college, and the consequence is that the patient who is prostrated by illness and appears very nearly dead is hindered in his progress by a load of strychnine or digitalis or any other stimulant. These things are not always adjusted by the chief, but the chief should keep them in mind.

Dr. Levison, closing: There have been several points discussed which have been incorporated in my paper. The first point mentioned was in reference to cachexia. All surgeons of experience have had patients come to them with inoperable carcinoma of the breast, uterus or intestines where cachexia was quite absent. This, consequently, should not be taken too seriously. Concerning visible peristalsis, I have on numerous occasions failed to see the peristaltic movements in bowel obstruction, because of the thick abdominal walls, even when the light has been most favorable; so that the bowel obstruction is not to be excluded when this sign is absent. The point mentioned by Dr. Bush, as to why the mortality should be 87% in enterostomy, performed for gangrenous hernia, and why it is 37% when the bowel is resected, is due in my opinion to the fact that resection is done early, before toxemia has developed, while enterostomy is performed in the last stage. This will account for the difference in the death rate.

Dr. Carpenter's statement in reference to stimulation I will answer by stating that the hypodermic syringe and saline infusion is practically unknown in my operating-room service, and it is due to the fact that my patient receives a very small quantity of anesthetic and is practically awake before leaving the table. My belief is that the surgical shock is not the result of the operation, but it is due to the excessive quantity of the anesthetic given. Post-operation nausea occurs but rarely in my service and I believe it to be also due to the fact that but a small quantity of ether is administered. The only indication to me for the employment of the saline infusion is where hemorrhage has occurred. Dr. Cooper brought up the point in regard to the blue line on the gums as a diagnostic point in lead poisoning. In my experience this is not pathognomic of lead poisoning. I have seen numerous cases of lead poisoning where the blue line on the gums was not present, and it is present principally with individuals who do not clean their teeth. The question of auscultation of the abdomen is very important. As I have stated, the position of the gurgling oftentimes makes it possible to locate the point of intestinal obstruction. In these cases the gas can be heard passing through the stenotic area.

SONOMA COUNTY.

Another fine meeting of Sonoma Medical Society chronicled. Dr. W. W. Kerr, of San Francisco, was heartily received, and he gave a lecture that all felt they could not have missed. The lecture will be published in full in the Journal. Dr. G. A. J. Scheuer was elected to membership.

After a fine chicken dinner the members autoed home, bringing with them Dr. Kerr, and arriving at Santa Rosa after midnight.

Ex-president Dr. J. W. Jesse has gone to attend the International Tuberculosis Congress, having been appointed by Governor Gillett a delegate.

G. W. MALLORY, Secretary.

SANTA CLARA COUNTY.

The regular Society meeting was held Sept. 16th in the Science Room of the new High School with the following members present: Drs. Jordan, Avery, Gallimore, Silvia, Hervey, W. S. Van Dalsem, Miller, Wagner, Smith, S. B. Van Dalsem, McGintl, Kapp, Hopkins, Simpson, Belknap, Kocher, Newell and Park. The visitors were Drs. Grant, Selfridge, Blake and Rucker of San Francisco, and Drs. Benepe, Bowen, La Breck, West and Wilson of San Jose. Three new members were admitted by application and one by transfer. Drs. H. B. Gates, Amelia Gates and D. R. Wilson by application and Dr. J. H. West by transfer from Contra Costa County.

Dr. Grant Selfridge read a short history on the subject of Bronchoscopy, as well as describing the instruments used. Lantern slides were used to show normal and pathological condtions met with in the use of the Bronchoscope. Drs. Selfridge, Blake and a nurse now prepared a patient for demonstrating the passing of the tube and after it was in place those present were given the opportunity of looking through the tube. Every one present greatly enjoyed Dr. Selfridge's paper and demonstration and we hope he will appear before this Society again.

Dr. Rucker of the M. H. S. gave a most interesting talk on "Plague as seen by the camera," using several dozen lantern slides to illustrate his remarks. As few of the physicians in this vicinity knew of the actual work done by the M. H. S. during the plague epidemic, the slides shown were of great interest, and if the applause given Dr. Rucker is any criterion, he and several hundred more slides will be given a royal welcome by this Society any time he can come here again.

K. C. PARK, Secretary.

ALAMEDA COUNTY.

The regular meeting of the Alameda County Medical Association was called to order at 8:45 p. m., President E. M. Keys in the chair. The minutes of the previous meeting were read and approved. Dr. A. Liliencrantz read a paper on "Fractures of the Skull," which was later followed by open discussion. The following resolution was indorsed unanimously by a standing vote:

Whereas, It has pleased Divine Providence to remove from our midst our esteemed colleague and brother, Dr. James P. Dunn, who by his professional attainments and skill, his service to public sanitation and his many good qualities of mind and heart have endeared him to his professional associates; therefore be it

Resolved, That we record our sense of loss at his untimely departure and extend our deepest sympathy to his bereaved family. Be it further resolved that a copy of these resolutions be forwarded to his widow.

Respectfully submitted,
DR. FRANK ADAMS,
DR. O. D. HAMLIN,
DR. H. G. THOMAS, Committee.

On the motion of Dr. H. G. Thomas a copy of the resolutions adopted by this society April 14, 1908, in regard to the plague situation, was ordered sent to the Board of Trade. Dr. E. N. Ewer read an official report of the plague situation, the work done, and present conditions, being the official report from the health office, signed by Dr. Long. The secretary read a letter from Dr. N. K. Foster, of Sacramento, endorsing our efforts in regard to the plague campaign.

Dr. A. Liliencrantz, synopsis of paper: Brain surgery is rapidly becoming a distinct specialty. Every surgeon, however, has a fair practical knowledge of what ought to be done in the ordinary injuries of the skull—2½ per cent of all fractures are of the skull. Don't always look for the clasical symptoms, because these are likely to vary; you may have practically no symptoms beyond the history of an injury to the head. Don't expect to make an immediate diagnosis. Treat every case symptomatically until you are sure of diagnosis. In regard to the location of an injury to the brain, acute troubles are more difficult to locate than slow growths or chronic conditions. Differentiate between intra- and extra-dural troubles if you can. Lumbar puncture will often facilitate the diagnosis in regard to fracture. In severe injuries Cushing states that 90 per cent of those not operated on die, especially when confined to the base of the skull, 60 per cent die within twenty-four hours. The modern method of making a large bone flap freely exposing considerable area of the brain surface and replacing the flap without any loss of bone, I think a very great improvement. It gives the operator a better chance to work. Don't forget that it is quite impossible to tell on which side the clot may be, it is well known that the hemorrhage may be on the same side as the motor symptoms.

The discussion was opened by Dr. R. T. Stratton, who stated that he believed the wide open incision indicated when necessary, but not as a regular procedure, sub-dural traumatism generally gives a higher temperature,—when in doubt always make a scalp incision and make a thorough examination of the skull. Drs. Bull, Adams, Porter and Buteau concluded the discussion. Dr. Buteau referred to a case that came under his care the fourth day after injury. The man had been beaten to unconsciousness by a gas-pipe thug, the lacerations in the scalp showed a dozen injuries, all of which were open and infected. A large scalp incision from the left temporal to the right posterior occipital region was made, and half the skull exposed, dissecting back the periosteum with the flap, the skull looked like a chicken board, the bones broken in small pieces, dirt and infection making their replacement impossible. Thirty-two square inches of bone were thrown away, ample drainage established, and the scalp replaced. The recovery was uneventful, patient regaining consciousness in two days. He attributed his success in this case, not to any special surgical skill, but to the radical measures adopted and the fact that the brain did not become infected.

During August 25th and 26th, Dr. Joseph Price of Philadelphia was a guest of this society. On August 25th a surgical clinic was held at the County Hospital; on the evening of August 26th a banquet was given in his honor at St. Marks, both of which were well attended.

The doctor proved himself a most genial guest, as well as a skillful surgeon, talking freely on all surgical questions; the clinic at the hospital included a perineal repair, vaginal hysterectomy and a laparotomy for pyosalpinx. One hundred and twenty-eight physicians were present, some forty automobiles being used.

Dr. Price congratulated Alameda County in having so many up-to-date hospitals and especially referred to our county institution, which was a first-class hospital and not an almshouse. He thought this institution far in advance of many of our eastern states. He thanked the society for the courtesies shown him and congratulated us on the harmony that seemed to prevail among the physicians here.

M. LEWIS EMERSON, Secretary.

CONCERNING THE ABBOTT ALKALOIDAL COMPANY.

"This Journal is in receipt of a letter, dated July 22, 1908, from Dr. W. C. Abbott, president of the Abbott Alkaloidal Company, which reads in part as follows: 'The good and welfare of the medical profession, as well as justice to ourselves, demand that we no longer remain silent in this matter of the continued unjust and absolutely unwarranted attacks being made upon us through the Journal of the American Medical Association by a coterie of people led by its editor who are using its pages for some ulterior purpose best known to themselves.' The writer than says that a pamphlet explaining his position is being forwarded to us, and continues: 'We bespeak for this presentation your most earnest attention. The interest of the profession you serve demands that you peruse it carefully and that you express your sentiments fully in your own publication.'